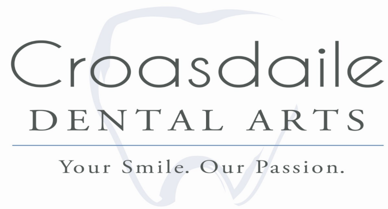

Drs. Turner & Butler, DMD, PA
Dba: CROASDAILE DENTAL ARTS
2900 Croasdaile Dr, Ste 5
Durham, NC 27705
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919-383-7402 office
866-383-3748 fax

RECORDS RELEASE

Patient Name:
____

Address:
____
____

Date of Birth:
____

I hereby authorize the release of copies of my dental records:________
I hereby authorize the release of copies of my dental x-rays:_________

To: Dr./Practice Name:
____

Address:
____
____

Telephone:
____

Dr./Practice Email Address:
____

This authorization shall be in effect until the information has been forwarded or requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing the authorization and that I have the right to refuse to sign the authorization. I understand that the information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document.

____
Patient Signature **Date**

Updated 07/25/19